



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

FERNANDO T AVILA MD
PO BOX 120040
SAN ANTONIO TEXAS 78212

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

HIDALGO COUNTY

Carrier's Austin Representative Box

Box Number 21

MFDR Tracking Number

M4-11-3196-01

MFDR Date Received

May 20, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carriers [sic] denial is incorrect as the appropriate modifiers were billed to allow the charges to unbundle, According [sic] to 2010 Encoder professional, the appropriate modifiers were billed to allow the charges to unbundle, as more than one procedure was performed, and they are not included in each other as they are totally different procedures. See operative report. In addition, ALL workers compensation carrier are to follow Medicare guidelines, which indicate that the Carrier s denial is incorrect as well."

Amount in Dispute: \$200.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have contacted our bill auditing company and have this response from them, Code 77003 is inclusive of 72275 per the 2011 CPT code book and Medicare. The provider is billing it with a 59 modifier to get it paid. This modifier is added when a procedure is a separate identifiable service with this is not. The 59 modifier does no [sic] apply."

Response Submitted by: Tristar Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 1, 2011	77003	\$200.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, sets out the fee guidelines for professional medical services provided on or after March 1, 2008.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- ANSI97 – 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 309 – The charge for this procedure exceeds the fee schedule allowance
- 86 – Service performed was distinct or independent from other services performed on the same day
- W1 – Workers compensation state fee schedule adjustment
- QA – The amount adjusted is due to bundling or unbundling of services.

Issues

1. Is the requestor seeking dispute resolution for date of service January 1, 2011 or February 1, 2011?
2. Did the requestor bill in conflict with NCCI edits?
3. Did the requestor meet the documentation requirements for modifier -59?
4. Is the requestor entitled to reimbursement?

Findings

1. Review of the table of disputed services indicates disputed date of service January 1, 2011, however the EOB and the CMS-1500 both indicate date of service February 1, 2011. The division will therefore review date of service February 2, 2011 in this dispute as the date of service provided on the table of disputed services appears to be a typo.
2. 28 Texas Administrative Code §134.203 states in pertinent part, “(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.”
 - NCCI edits were run to identify if the disputed charges contain edit conflicts.
 - The requestor billed the following CPT codes on February 1, 2011: 64483-50, 64484-50, 72275-59, 77003-59 and 72100-59.
 - Per CCI Guidelines, Procedure Code 77003 has a CCI conflict with Procedure Code 64483. Review documentation to determine if a modifier is appropriate.
3. The CPT Manual defines modifier -59 as follows: Modifier -59: "Distinct Procedural Service: Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries)not ordinarily encountered or performed on the same day by the same physician. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.”
 - The requestor did not meet the documentation requirements for appending modifier 59. As a result reimbursement cannot be recommended for CPT code 77003.
4. Review of the submitted documentation finds that the requestor is not entitled to reimbursement for the disputed charges.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	July 12, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.